**PETITION FOR REIMBURSEMENT OF OUT-OF-POCKET PRESCRIPTION COSTS ON MEDICARE PART D PLAN**

**I, _____, certify that I am a State of Idaho retiree and was covered under the state's Retiree Medical Plan at some time during calendar year 2009. I am covered for prescription costs under a Medicare Part D prescription plan. I am in the coverage gap in that plan and have paid over $2,000 in medication costs out-of-pocket while in the gap. I am requesting reimbursement of up to $2,000 for additional expenses that I have incurred beyond the initial $2,000 paid in the coverage gap.**

**I understand that this reimbursement is considered as taxable income. I also understand that any reimbursement made to me under the program will be reported to CMS which will delay my reaching the catastrophic benefit on my Medicare Part D prescription plan.**

**I have included a completed Prescription Drug Assistance Benefit Reimbursement Form along with proof that I am in the Part D coverage gap, and that my expenditures in the gap have exceeded $2,000. Also included is proof of my additional expenses for which I am claiming reimbursement.**

_____ _____

**First Name Last Name** **Signature**

_____ _____

**Street Address** **Date**

_____

**City, State, Zip**